Codify
BY AAPC

# Part B Insider (Multispecialty) Coding Alert

## Reader Question: Don't Always Add Together Lesion Sizes

Question: Following a melanoma excision, our surgeon performed a layered closure. I've heard that we should add the dimensions of the lesion excision to determine the code choice for the closure -- is this correct?

Arkansas Subscriber

Answer: No, you should not base the closure code on the lesion excision size at all. Instead, you should base it on the closure size. When the surgeon excises a lesion, the code includes simple (single layer) closure. But if the surgeon performs a layered closure as you described, you can separately bill the intermediate closure.

Do this: What you need to know to bill the closure is the longest dimension of the wound. This is likely to be quite a bit longer than the excision itself, because surgeons often create an elliptical excision, which is easier to close. You will identify the total length of the repair and choose the intermediate repair code that matches that length.

For instance: The surgeon creates an elliptical excision 6 cm long surrounding a 2.5 x 1.5 x 1.0 cm lesion excision with 1 cm margins on the scalp. You should report the intermediate repair as 12032 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.6 cm to 7.5 cm) in addition to the excision code (11604, Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 3.1 to 4.0 cm).

These rules for closure coding apply for excision of benign and malignant lesions of both the integumentary system (114xx -- 116xx) and the musculoskeletal system for lesions such as lipomas (for example, 21011, Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm). The only difference is that you can only separately report complex repair with muscle/soft tissue lesions, while you can separately report intermediate and complex repair with integumentary lesions.